

REQUEST FOR SURGICAL OUTPATIENT APPOINTMENT – FAX 5226 7054



REFERRING GENERAL PRACTITIONER DETAILS:

Name:
Practice Name:
Address:
Telephone:
Fax:
Email:
Provider No:

CONSUMER DETAILS:

Surname: Forename: Postcode:
Address: Suburb: Telephone:
Sex: Date of Birth: Age:
Alternative Contact Person:
Medicare Number:
DVA: Yes Number: WorkCover: Yes Number: TAC: Yes Number:

Patient Aboriginal or Torres Strait Islander: Yes No Interpreter required: Yes No Language:

REFERRAL DETAILS:

DATE OF REFERRAL:

SPECIALTY:

Urgency: Urgent Recurrent Problem: Yes No
Semi-urgent
Non-urgent Is this a second referral for this health problem: Yes No

REASON FOR REFERRAL AND CLINICAL INFORMATION:

(Please state information regarding effects on lifestyle, work, ADLs or family situation that may influence urgency)

Colonoscopy: Yes No **Type of FOB screening:** N/A Rotary GP ordered National Bowel Screening

MEDICATIONS:

ALLERGIES:

Smoking: **Alcohol:** **Recreational drug use:**

PAST HISTORY:

INVESTIGATION RESULTS:

Signature of Referring Physician: **Date:**